UNAPPROVED DRAFT

BOARD OF DENTISTRY

MINUTES
SPECIAL CONFERENCE COMMITTEE "A" MEETING

TIME AND PLACE: Special Conference Committee "A" convened on January 4, 2008 at 9:21 a.m., at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Richmond, VA 23233.

APPROVAL OF MINUTES: Ms. Pace moved to approve the minutes of the Special Conference Committee "A" meeting held on November 16, 2007. The motion was seconded and passed.

PRESIDING: Meera A. Gokli, D.D.S.

MEMBERS PRESENT: Jacqueline G. Pace, R.D.H.

STAFF PRESENT: Alan Heaberlin, Deputy Director
Cheri Emma-Leigh, Operations Manager
Leigh C. Kiczales, Adjudication Specialist

QUORUM: Both members of the Committee were present.

Robert E. Cruickshanks, D.D.S.
Case Nos. 100272, 108023, 108504, 109546 and 112130

As a preliminary matter, Robert E. Cruickshanks, D.D.S. requested a continuance on January 3, 2008, and the continuance was denied by the Chair of the Committee. Dr. Cruickshanks did not appear to discuss allegations that he may have violated laws and regulations governing the practice of dentistry, in that

1. He may be mentally incompetent to practice his profession with safety to his patients and the public due to an Axis I diagnosis rendered on March 30, 2007, of major depression recurrent with psychotic features for which treatment was recommended.

2. On August 7, 2004, during his treatment of Patient A, he failed to properly expose tooth #11 in preparation for orthodontic work. During the procedure, he partially bracketed Patient A, and attached the braces at the level of the gum line rather than centered on the crown of the teeth.

3. He failed to present a treatment plan for Patient A prior to initiating treatment on August 7, 2004.

4. On or about February 2, 2006, he negligently extracted patient B's wisdom tooth #17, causing Patient B to suffer an acute left, lateral/medial mandibular fracture, which necessitated emergency surgery.

5. On or about August 14, 2004, during the extraction of Patient C's wisdom teeth, he failed to sedate Patient C completely, as she had requested. Further, while trying to extract tooth #17, he broke the top half of the tooth, leaving the bottom half impacted in her gum, causing Patient C tremendous pain. Following the procedure, Patient C experienced bleeding, cuts in the sides of her mouth, and swelling in her face for three (3) days, and bruising around her eyes, mouth and cheeks for approximately two (2) weeks following treatment.

6. In August 2004, he attempted to obtain payment for services not rendered during his treatment of Patient C. Specifically, he billed Patient C's insurance company for two (2) extractions on August 19, 2004, when the only work performed on that date was the removal of one (1) suture.

7. He failed to cooperate with the Board's investigators by refusing to produce requested and/or subpoenaed dental records, and by failing to respond to the investigators' attempts to schedule interviews and/or inspections of his office in connection with the various complaints filed against him.

8. His advertisements in the 2006 and 2007 *Verizon* White and Yellow Pages identify one office of his dental practice as being located at 8804 Patterson Avenue, and lists a phone number of (804) 754-2125. The Board's investigator was unable to locate any office bearing his name at that address. In addition, telephone calls placed to the phone number listed for that address are referred and/or

forwarded to another office located at 501 Twin Ridge Lane, approximately ten (10) miles away.

9. During 2005 and 2006, he failed to provide dental records to his patients.

Leith Ellis, Senior Investigator, and Pam Twombly, Regional Supervisor, were present and available to give statements should the Committee have any questions. Also, available by telephone, was Martha Miller, Senior Investigator.

Closed Meeting: Ms. Pace moved that the Committee convene a closed meeting pursuant to § 2.2-3711(A)(28) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of Robert E. Cruickshanks, D.D.S. Additionally, Ms. Pace moved that Board staff, Alan Heaberlin, and Cheri Emma-Leigh, and Administrative Proceedings Division staff, Leigh Kiczales, attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Committee in its deliberations. The motion was seconded and passed.

Reconvene: Ms. Pace moved to certify that only matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Committee. The motion was seconded and passed.

The Committee reconvened in open session pursuant to § 2.2-3712(D) of the Code.

Decision: Ms. Kiczales read the Findings of Fact and Conclusions of Law and Sanctions imposed as adopted by the Committee as follows:

1. Dr. Cruickshanks currently holds a Virginia dental license.

2. Dr. Cruickshanks violated § 54.1-2706(8) of the Code, in that, he is unable to practice his

profession with safety to his patients and the public due to an Axis I diagnosis rendered on March 30, 2007, of major depression recurrent with psychotic features for which treatment was recommended.

3. Dr. Cruickshanks violated § 54.1-2706(5) of the Code, in that, on August 7, 2004, during his treatment of Patient A, he failed to properly expose tooth #11 in preparation for orthodontic work. During the procedure, he partially bracketed patient A, and attached the braces at the level of the gum line rather than centered on the crown of the teeth.

4. Dr. Cruickshanks violated § 54.1-2706(9) of the Code, and 18 VAC 60-20-170(2) of the Regulations, in that he failed to present a treatment plan for Patient A prior to initiating treatment on August 7, 2004.

5. Dr. Cruickshanks violated §§ 54.1-2706(5) and (11) of the Code, in that, on or about February 2, 2006, he negligently extracted Patient B's wisdom tooth #17, causing Patient B to suffer an acute left, lateral/medial mandibular fracture, which necessitated emergency surgery.

6. Dr. Cruickshanks violated §§ 54.1-2706(5) and (11) of the Code, in that, on or about August 14, 2004, during the extraction of Patient C's wisdom teeth, he failed to sedate Patient C completely, as she had requested. Further, while trying to extract tooth #17, he broke the top half of the tooth, leaving the bottom half impacted in her gum, causing patient C tremendous pain. Following the procedure, Patient C experienced bleeding, cuts in the sides of her mouth, and swelling in her face for three (3) days, and bruising around her eyes, mouth and cheeks for approximately two (2) weeks following treatment.

7. Dr. Cruickshanks violated §§ 54.1-2706(4) and (9) of the Code, and 18 VAC 60-20-170(1) and (6) of

the Regulations, in that, in August 2004, he attempted to obtain payment for services not rendered during his treatment of Patient C. Specifically, he billed Patient C's insurance company for two (2) extractions on August 19, 2004, when the only work performed on that date was the removal of one (1) suture.

8. Dr. Cruickshanks violated §§ 54.1-2706(9), 54.1-2703, and 54.1-111.A(7) of the Code, in that, on several occasions in 2005 and 2006, he failed to cooperate with the Board's investigators by refusing to produce requested and/or subpoenaed dental records, and by failing to respond to the investigators' attempts to schedule interviews and/or inspections of his office in connection with the various complaints filed against him.

9. Dr. Cruickshanks violated §§ 54.1-2706(4), (7) and (9) of the Code, and 18 VAC 60-20-180(F)(1) and (2) of the Regulations, in that his advertisements in the 2006 and 2007 *Verizon* White and Yellow Pages identify one office of his dental practice as being located at 8804 Patterson Avenue, and lists a phone number of (804) 754-2125. The Board's investigator was unable to locate any office bearing his name at that address. In addition, telephone calls placed to the phone number listed for that address are referred and/or forwarded to another office located at 501 Twin Ridge Lane, approximately ten (10) miles away.

10. Dr. Cruickshanks violated §§ 54.1-2706(9) and 32.1-127.1:03(E) of the Code, and 18 VAC 60-20-170(4) of the Regulations, in that, during 2005 and 2006, he failed to provide dental records to his patients.

The sanctions reported by Ms. Kiczales were that pursuant to § 54.1-2400(15) of the Code, Dr. Cruickshanks shall enter into a participation contract with the Health Practitioner Intervention Program, ("HPIP") for a

comprehensive multi-disciplinary assessment. Further, Ms. Kiczales reported that pursuant to § 54.1-2400(10) of the Code, Dr Cruickshanks be issued a reprimand, be assessed a monetary penalty of $15,000.00 and be placed on probation for not less than two (2) years, complete seven (7) continuing education hours in recordkeeping and risk management, complete four (4) continuing education hours in ethics, complete seven (7) continuing education in diagnosis and treatment planning, and be required to successfully pass the Board's dental law exam.

As provided by law, this decision shall become a Final Order thirty days after service of such on Dr. Cruickshanks unless a written request to the Board for a formal hearing on the allegations made against him is received from Dr. Cruickshanks. If service of the order is made by mail, three additional days shall be added to that period. Upon such timely request for a formal hearing, the decision of this Committee shall be vacated.

ADJOURNMENT: With all business concluded, the Committee adjourned at 12:10 p.m.

Meera A. Gokli, D.D.S., Chair

Sandra K. Reen, Executive Director

Date

Date